City of Lodi GrapeLine Discount Fare ID Card Application ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL



Date: Date of Birth: Mr. Mrs. Ms. Malling Address: First Name: Mr. Mrs. Ms. Malling Address: E-mail Address: Mr. Mrs. Ms. Yes, I'd like to receive occasionale -mails about important service information, news, and schedule changes. If someone other than the applicant is completing this application, please fill out the following: Last Name: First Name: Mr. Mrs. Ms. Address: City: Zip: Zip: Phone Number: Agency: Zep: Zep: Zep: Zep: Section 2 Type of Discount Fare ID Card Requested (*Please check one of the following): Zep: Zep:	Section 1 Personal Information						
Last Name: First Name: City: Zip:		Da	to of Dir	·h·			
Mailing Address: City: Zip:					Mr Mrc Mc		
Phone Number:				City			
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Staff: ID Number:	Evidence received, certified and approved. Confidentia	al evidence sh	redded by	Staff.			
	Staff: Date	e:		ID Number:			

Certification Form for People with Disabilities



(Only complete if you do not have another proof of disability, as listed in Section 2)

Section 4 Applicant Authorization				
Applicant's Name:	Applicant's Date of Birth:			
I hereby authorize the person listed in Section 5 of this applicati or other pertinent information about my disability. The informa eligibility for this Disabled Discount Fare Card. I understand that returned.	tion released will be solely used to determine my			
Signature	e			
Section 5 Medical Professional Verification				
The above named individual is applying for a City of Lodi GrapeLine Disabled Discount Fare Card. The City of Lodi offers a 50% discount for disabled persons based on federal regulations as defined in 49 CFR § 609.3:				
"those individuals who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair-bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected."				
To process this request, please provide the following informat	on:			
Medical diagnosis of disability. Please type or print clearly and	do not use medical abbreviations:			
How does this disability affect applicant's ability to utilize mass transportation?				
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Permanent: conditions with absolutely no expectation of improvement				
☐ Permanent: conditions with absolutely no expectation of Temporary: expected duration from				
Does the applicant use a mobility aid?				
☐ Yes ☐ No If yes, what type?				
Manual Wheelchair Power Wheelchair Power Scoo	oter Walker			
Cane Crutches Service Animal				
I certify that meets the eligibility criteria as transportation disabled. I declare under penalty of perjury under the laws of the State of California that the information I have given is true and correct. If this application is not complete, it will be denied.				
Signature Date				
Printed Name: Licens	e #:			
Organization:	Phone #:			
Organization Address:				